VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 24, 2015

Ms. Becky MacDonald, Manager
Loch Lomond
700 Willson Road
North Concord, VT 05858-7007

Dear Ms. MacDonald:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 20, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0062	A. BUILDING: _____ B. WING _____	C 05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCH LOMOND	700 WILLSON ROAD NORTH CONCORD, VT 05858

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R100	Initial Comments: An unannounced onsite re-licensing survey, and investigation of one complaint and two self-reported incidents, was conducted by the Division of Licensing and Protection from 5/19-5/20/15. The following regulatory deficiencies were identified.	R100		
R110 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.2 Admission 5.2.b. On admission, the home must also determine if the resident has any form of advance directive and explain the resident's right under state law to formulate, or not to formulate, an advance directive. Any change of rate or services shall be preceded by a thirty (30) day written notice to the resident and the resident's legal representative, if any. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to document that information on how to formulate Advanced Directives was provided on admission for 2 of 5 sampled residents (Resident #1, #5). Findings include: Per record review on 5/19- 5/20/15, two of the five resident assessments reviewed indicated that they did not have Advanced Directives (for Residents #1, #5). There was no documentation that these residents received the information regarding the formulation of Advanced Directives. Per interview on 5/20/15 at 2:15 PM, the Manager of the home stated that the assessment forms indicated that Residents #1 and #5 did not have	R110	I have gone back to #1 and #5 Residents and given each of them information on how to Formulate Advance directives Each of these residents have declined wanting this information and/or help in formulating Advanced Directives. I have Documented this in each of the residents records on their Resident Assessment Forms next to the section Refering to Advanced Directives. This was completed on May 26, 2015. To ensure this deficient practice does not recur we have added instructions to document the receipt or refusal of Information of Advanced Directives by each resident into the Residents Assessment Forms for each of our residents and any new Resident Admissions. This will be monitored by our manager & our Registered Nurse when they do New admissions and again Annually while doing each Resident Assessment.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Becky L. MacDonald — Owner/manager — 6/15/2015

R110 - R302 POC accepted 6/24/15 KCampos RN/PME

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R110	Continued From page 1 previously completed Advanced Directives, and that there was no documentation to indicate they had been provided with the information on how to formulate one if they wished to.	R110		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the Registered Nurse participated in the development and oversight of the written plan of care for 4 of 5 residents in the survey sample (Resident #1, 2, 3, and #4). Findings include: Per record review on 5/19- 5/20/15, Residents #1, 2, 3, and 4 had a plan of care in the record that was written and signed by the Home Manager, with no evidence that the Registered Nurse had participated in or reviewed the plan of care. Per interview on 5/20/15 at 10:15 AM, the Manager of the home confirmed that the plan of care was developed for these residents without the input or review from the Registered Nurse.	R145	Our Registered nurse has Reviewed all care plans for all of our residents including those of Residents #1, 2, 3, 4. She has given her input and/or excepted the care plans as written. She completed these on May 24, 2015. We have Added Instructions on how to Develop Resident Care Plans into both our Policy & Procedure manual and our Care Plan booklet. Our Nurse and our homes manager will both oversee this in the Future by having Scheduled Care Plan Meetings where the Nurse + the manager are both present for input and signing off that Care plans have been developed and/or reviewed by both parties	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES	R167		

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R167	Continued From page 2 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that psychoactive medications given on an as needed basis had clear indications for use for 1 of 5 residents reviewed. (Resident #1). Findings include: Per record review on 5/20/15, Resident #1 had an order for Diazepam (Valium) that was written on 11/21/14. The signed order reads "Increase Valium 5 mg. 1-2 PO PRN QD anxiety". There is no nursing indication for the the staff to know when to give one 5 mg. tab or two 5 mg. tabs, and the order does not indicate when it would be appropriate to give one or two tabs. Per interview on 5/20/15 at 2:45 PM, the home Manager confirmed that the order was not clearly indicating the dose to be given with parameters to have unlicensed staff administer, and that the nurse had not clarified with the practitioner how the anti-anxiety medication order was to be used for	R167	we have Clarified with ~~the~~ Residents #1's provider the order for Diazepam to be given 5mg ÷ P.O. PRN for acute Anxiety. This takes away the range of ÷ to ÷÷ and gives a more clear indication for staff as to when to give to the resident. Because of the provider being out for several weeks we finally were able to finalize the Clarification on 6/15/15. We have placed in the Medication Administration Record Booklet Instructions as a reminder around the Clear perimeters, of PRN medication orders for all staff, including a reminder to the Registered Nurse and homes manager to Clarify any order that is not clear and without Ranges. The Registered Nurse will oversee this to ensure in the future it does not occur as well as when we receive telephone orders from physicians.	

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R167	Continued From page 3 this resident.	R167		
R181 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, the home failed to ensure that criminal background and/or abuse registry checks were completed for 3 of 6 employees sampled. Findings include: Per review on 5/20/15, one staff member had Adult and Child Abuse registry checks on file, but no results from a criminal background check through VCIC (Vermont Criminal Information Center). Per review of another staff member,	R181	I have reviewed all Staff Files and have conducted Adult and Child Abuse registry checks and Criminal background checks on all of the employees that were missing these from their Files. These were conducted/completed on 6/15/15. I have included instructions in our Policy and procedure manual as well as our hiring of new employees booklet on how to Conduct Adult + child Abuse registry checks and Vermont Crime Registry checks - along with website information, (username + password information is protected by homes manager.) This will help ensure that before new employees are hired these checks are complete. The manager will oversee this. The Nurse will also check these during her initial training of new staff.	

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R181	Continued From page 4 there was no record in the file that the criminal background check through VCIC or the Child Abuse Registry check were conducted for this employee. The third employee reviewed was missing both the criminal background check through VCIC and the Adult Abuse Registry check. Per interview on 5/20/15 at 2:45 PM, the home Manager confirmed that there was no record of these background checks completed for the employees with missing information in their files.	R181	Resident # 3 has been removed from our home Since the incident on 5/4/15. He was officially discharged from Loch Lomond on 5/15/15 after a team meeting with his gaurdians and Northeast Kingdom Human Services determined finding Alternate Placement would be beneficial for him and for our other residents. We have since developed a Clearer Policy & procedure for resident to resident Contact including the requirment that the home and staff are required to report incidents or suspected incidents of Abuse, neglect & exploitation in a timely manner to Adult protective Services All incidents will be reported first to our homes Managers and Registered Nurse. The managers will then Report to APS and depending on the Situation may or may not Call the State police. Casemanagement will also be called. If any injuries or suspected injuries occur the resident will be seen by a medical professional as well, either Nurse, ER, or PCP. This will be case by Case judgement Call by the managers and nurse. All incidents will be documented in Residents charts These policy's were completed on 5/27/15	
R207 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that allegations of resident to resident abuse were reported in a timely manner for 3 of 5 residents sampled. (Residents #2, 3, 4). Findings include: Per record review on 5/19 - 5/20/15, there was an incident that occurred on 5/4/15 involving a physical altercation. Resident #3 was in the kitchen and according to staff report, became	R207		

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R207	Continued From page 5 very angry with Resident #2, swore at the other resident and pushed them. Resident #2 fell back, hitting the refrigerator and the cupboard, and landing on the floor. This was reported by both the therapist of the alleged victim and the home Manager to Adult Protective Services, however the home manager did not report this incident until 5/6/15, after being told by a nurse at the doctor's office that it needed to be reported. Another incident occurred on 3/14/15, between Resident #3 and Resident #4, that involved an alleged physical altercation between the two residents. Resident #4 alleged that a verbal argument took place between the two, and that Resident #3 punched them in the back of the neck. There were no injuries noted, and there was a question of whether this had actually happened as the reporter is not always reliable. Per interview on 5/20/15 at 3:10 PM, the home Manager confirmed that the alleged incident in March and the witnessed incident in May as listed above were not reported to the state agency within the required timeframe.	R207		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	R247	After vacuuming dust off the back of the refrigerator vents and removing all perishable items we called our Appliance repair man. on 5/20/15 He came out to our home on 5/22/15 He looked in the Freezer where there is a duct that had been turned to a closed position, choking off colder Air from getting Forced down into the refrig section. After opening this duct back up and allowing the colder Air to circulate into the	

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R247	Continued From page 6 home failed to ensure that food was stored at the proper temperature. Findings include: Per observation on 5/20/15 at 9:15 AM, the thermometer in the kitchen refrigerator read 48 Degrees Fahrenheit (Deg. F.) After comparing the results of a second thermometer to the one in use in the kitchen refrigerator, the readings were comparable at approximately 48 Deg. F. After leaving the refrigerator closed for approximately one hour, the temperature at 10:00 AM was 47 Deg.F. Check of the actual temperature of a bottle of juice in the refrigerator at that time was 41 Deg.F. The staff vacuumed the vents on the refrigerator which were coated with dust, and a recheck of the refrigerator temperature was done at 12:30 PM, and was 44 Deg. F. At 1:30 PM, the refrigerator was still reading 44 Deg. F. Staff removed the food to another refrigeration unit, and discarded any perishable items that would be at risk of spoiling in the warmer temperatures. Per interview on 5/20/15 at 1:30 PM, the home Manager confirmed that the refrigerator was not functioning correctly, and that the temperatures in that unit were not maintained at 41 Deg. F. or below.	R247	Refrigerator Section the temps quickly started to fall below 40° F and now have been hovering around a steady 37°F since 5/23/15 we have written on this duct w/ a magic marker indicating the position of where the duct should stay to maintain Cooler temperatures. All staff have been instructed of this Regulation and of the way this duct works & what position to keep the dial. All staff will monitor this daily & logging temps each day. The homes manager will do random quality assurance checks on a monthly basis to ensure this does not occur in the future.	
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to ensure that hot water temperatures in	R291		

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R291	Continued From page 7 resident areas did not exceed 120 Degrees Fahrenheit. Findings include: Per observation on 5/19/15, during a tour of the home, the hot water in a second floor bathroom usually utilized by the staff read 128 Degrees Fahrenheit (Deg. F.) at 11:15 AM. Upon further temperature checks, the hot water in the resident bathroom next to the staff bathroom on the second floor was reading 137 Deg. F. at 11:17 AM. The bathroom in Room 2, shared by two residents, had a hot water temp that reached 127 Deg. F. at 11:20 AM. In Rm. 5, which is presently occupied by one resident, read 123 Deg.F. at 11:30 AM. Per continued tour of the home with the Manager at 11:40 AM, s/he confirmed the temperatures were over 120 Deg.F. in all of these resident areas. Per continued tour of the hot water heater and the mixing valve gauge that regulates the temperature of the water going to the rooms, the gauge was reading between 135 and 140 Deg. F. The Manager was able to consult with a plumber over the phone, and able to turn down the mixer to cool the water. The temperatures decreased quickly in all resident areas, and were holding steadily below 120 Deg. F. for the rest of the afternoon, and all during the second day of survey on 5/20/15. Per interview on 5/20/15 at 9:45 AM, the home Manager confirmed that hot water temperatures were checked on a weekly basis, that they had been over 120 Deg.F. on 5/19/15, and that the mixing valve had probably been turned up unintentionally during a recent attempt to determine the source of a water drip in that area.	R291	on 5/20/15 we were able to consult with our plumber over the phone and able to turn the mixing valve down in order to maintain water temperatures at 120° or less. Until all residents areas were registering at 120° or less we posted warnings on all Faucets. Temps were checked for several days in a Row following this incident and all Faucets checked were maintaining at 120° or less. We have instructed all staff about where the mixing Valve is and how it works. We have also put a sign on this Mixing Valve Instructing when it should be turned to and how to turn it down if it becomes greater than 120°. Staff has instructed to keep an eye on this daily. With the Manager doing Monthly quality Assurance checks to ensure this does not happen Again.	

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R302	Continued From page 8	R302		
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the fire drill requirement for a residential care home was met. Findings include: Per record review on 5/20/15, the log of completed fire drills for 2014/15 showed that there were no drills conducted during the hours that residents were sleeping. Per interview on 5/20/15 at 2:15 PM, the Home Manager confirmed that all of the drills during 2014 and 2015 were conducted in the day or evening hours, with no fire drills conducted during the night to evaluate the resident's response to the alarm when they were asleep.	R302	We have conducted a nite time Fire drill on 6/1/15. In the future to ensure that these nite time drills take place we will schedule them a head of time. At times staff will be aware of these nite time drills and at other times Management may schedule without telling staff to ensure that staff is Also prepared in Nite time emergency and/or evacuation of residents. Management will oversee to ensure this deficiency does not recur. Instruction has been added to our Fire drill Manual and will be checked off when completed each time it has been performed Management will do monthly quality ASSurance checks to Make Sure these nite time drills have been conducted at Least twice yearly. Completed 6/1/15 as well as Hother drills anytime day or Nite.	